STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165602	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Care Center of Fairfield	400 Highland Street Fairfield, IA 52556

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on record review, staff interviews, and facility policy review, the facility failed to notify the physician when a resident's blood glucose over 450 mg/dl (milligrams/deciliter) for 1 of 3 residents reviewed (Resident #4). The facility reported a census of 60 residents. Finding include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 scored a 12 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated cognition moderately impaired. The MDS revealed a diagnosis of Type II DM (diabetes mellitus) without complications. The MDS revealed the resident received insulin 7 out of 7 days. The Care Plan revealed the focus area for Type II DM and currently took Humalog and Tresiba dated 11/3/23. The interventions dated 11/3/23 revealed monitor, document, and report signs and symptoms of hyperglycemia such as increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing, acetone breath (smells fruity), stupor, and coma. The EMR (Electronic Medical Record) revealed the Medical Diagnosis for Type II DM without complications. The Physician Orders revealed a. start date 12/19/23: check blood glucose before and after meals four times a day and notify the primary care provider is less than 60 mg/dl (milligram/deciliter) or greater than 450 mg/dl The Blood Sugar Summary revealed the following dates the blood sugar over 450 mg/dl and the facility lacked documentation in the Progress Notes, the provider was notified of the elevated blood glucose readings: a. 4/16/24 at 11:58 AM- blood glucose 458 b. 4/28/24 at 5:29 PM- blood glucose 544 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. 5/14/24 at 8:11 PM- blood glucose 463 d. 5/15/24 at 5:24 PM- blood glucose 512 e. 5/15/24 at 8:17 PM- blood glucose 558 During an interview on 5/22/24 at 12:51 PM, Staff B, RN (Registered Nurse), confirmed if a resident's blood glucose was above 450 mg/dl, they notified the doctor. During an interview on 5/23/24 at 11:15 AM, the DON (Director of Nursing), stated if a blood glucose was over 450 mg/dl and the reading was on a Tuesday or Friday, the nurse notified the provider while they were in the building. She stated they notified the physician and put in a note of what the doctor ordered such as to continue to monitor or an as needed order. During an interview on 5/23/24 at 2:24 PM, the DON stated she spoke to the CMA's (Certified Medication Aides) who took the blood sugars and they told her they let the nurse know the blood sugars and the nurses stated they let the physician know and didn't always chart it. She stated the staff get busy and were not always near a computer to chart it. During an interview on 5/23/24 at 2:32 PM, the Administrator stated they notify the physician with elevated blood sugars and the notification would come from the tablet and transport to the electronic medical record, and then the staff needed to chart it but they got busy. The Administrator confirmed the staff needed to document the notification. The Facility Blood Glucose Monitoring dated 12/23 revealed: a. report critical test results to physician timely. b. document the procedure.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on observation, interview, record review, and facility policy review, the facility failed to answer a call light in less than 15 minutes for 1 of 3 residents reviewed for insufficient number of staff (Resident #1). The facility reported a census of 60 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 scored a 13 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS revealed the resident used a walker and wheelchair for mobility. The MDS revealed the resident needed partial/moderate assistance with toileting hygiene and toilet transferring. The MDS revealed a diagnosis of cerebral palsy. The Care Plan revealed a focus area for risk for falls related to gait and balance problems dated 9/28/23. The interventions dated 9/28/23 revealed making sure call light within reach and encourage to use it for assistance when needed and prompt response to all requests for assistance. During an observation on 5/20/24 at 2:50 PM- Resident #1 call light was on. Heard running water and the resident not on her bed. The bathroom light was on and the bathroom door open. During an observation on 5/20/24 at 3:00 PM, heard the water turned off, and heard the resident say could someone help me. The resident banged something on the floor. During an observation on 5/20/24 at 3:01 PM, the resident continued to bang something on the floor. During an observation on 5/20/23 at 3:06 PM, the resident cried out, and said was anybody out there, it has been an hour. During an observation on 5/20/24 at 3:07 PM, staff walked into her room after knocking. During an interview on 5/20/24 at 3:19 PM, Resident #1 stated she had to clean herself up. She stated she waited for almost an hour before staff came in. Resident #1 stated she took her phone in the bathroom with her and watched the time. She stated it was closer to 48 minutes she waited for help. She stated she had poop everywhere and took the potty chair and pounded it on the floor to get someone's attention. During an interview on 5/22/24 at 12:51 PM, Staff B, RN (Registered Nurse) stated call lights needed to be answered in a maximum of 10 minutes. During an interview on 5/22/24 at 1:21 PM, Staff C, CNA (Certified Nurse Aide) stated call lights needed answered within 15 minutes and if able before then. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/24 at 1:39 PM, Staff D, CNA stated call lights needed answered in 5 minutes or as soon as possible and in order of who put the light on first or the urgency of the matter. During an interview on 5/23/24 at 11:15 AM, the DON (Director of Nursing) stated call lights needed answered within 15 minutes and sometimes there were exceptions if everyone's light was on, but the staff needed to tell the residents they would be back. She stated she knew they tried to get to Resident #1 as soon as they could because she liked to self transfer. The Facility Call Light Accessibility and Timely Response Policy dated 12/23 revealed the following: a. All staff members who see or hear an activated call light were responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47336 Based on observation, staff interview, and facility policy review, the facility failed to serve mandarin oranges at the appropriate temperature; they failed to serve the room trays at the appropriate temperature; and touched food on a plate with gloves and did not remove the gloves after handling the food or wash their hands. The facility reported a census of 60 residents. Finding include: During an observation on 5/22/24 at 12:05 PM, Staff A, Cook checked the temperatures of the lunch food prior to service revealed the following: a. broccoli 168.5 degrees F (Fahrenheit) b. pork loin 166.2 degrees F c. potatoes 147.4 F degrees F d. mandarin oranges 42 degrees F During an observation on 5/22/24 at 12:10 PM, lunch meal service began. Staff A wore gloves during meal service. During an observation on 5/22/24 at 12:19 PM, Staff A moved over the resident's broccoli and potatoes using her gloved hand on the plate, and didn't remove gloves after touching the food on the plate. During an observation on 5/22/24 at 12:23 PM, Staff A put potatoes on the plate and then used her hand to push the potatoes over on the plate, and didn't remove gloves after touching the food on the plate. During an observation on 5/22/24 at 12:25 PM, Staff A used her glove hand to push over the pork loin on the plate before placing other food on the plate and didn't remove her gloves after touching the food on the plate. During an observation on 5/22/24 at 12:31 PM, Staff A did the post-meal service temperatures. The temperatures of the post meal revealed the following: a. pork loin 161.7 degrees F b. broccoli 169.3 degrees F c. potatoes 137.4 degrees F d. mandarin oranges 51 degrees F (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/22/24 at 12:40 PM, the Dietary Manager checked the temperatures on the test tray on the end of the hall and temperatures read the following: a. pork loin 127.4 degrees F b. broccoli 125.3 degrees F c. potatoes 107.4 degrees F d. mandarin oranges 50 degrees F During an interview on 5/22/24 at 1:55 PM, Staff A acknowledged the fruit was 1 degree above the temperature it was supposed to be before service. Staff A acknowledged she used her gloved hand to move the food on the plates and stated she should have used tongs. Staff A stated she should have removed her gloves and washed her hands after touching the food on the plate. During an interview on 5/22/24 at 2:02 PM, the Dietary Manager stated she thought the temperatures were all good except for the temperatures at the end of the hall. She stated she didn't know how to avoid the low temperatures because they used an insulated cart and a hot tray. She stated if residents had problems with the food temperatures, they came and talked to her. The Dietary Manager stated Staff A should have used a spatula to move the food on the plate or changed her gloves and washed her hands. During an interview on 5/23/24 at 1:23 PM, the Dietician was informed the the pre, post, and test tray temperatures of the lunch meal on 5/22/24 and she stated there needed to be definite education and review of the temperatures and what not to be serving. She stated they needed reeducation and not to serve that item if not in the temperature range because you didn't want to risk food borne illness. She stated she would have tossed the mandarin oranges. She stated the temperatures needed to be above 135 degrees for hot food and 41 degrees or lower for cold foods. She stated she would speak to the Dietary Manager about danger zone temperatures. During an interview on 5/23/24 at 1:31 PM, the Administrator stated the temperature of the potatoes surprised her and the hot plates are blazing hot, and she was checking the temperatures and the Dietary Manager was working on the temperatures. The Administrator was asked her expectation of the food temperatures and she stated to follow the guidelines. The Administrator informed of the gloved hand touching the food on the plate and she stated she expected the gloves be removed, hands washed, and new gloves applied. The Facility Proper Hand Washing and Glove Use Guideline and Procedure Manual dated 2020 revealed the following: a. Gloves are to be used whenever direct food contact is required. b. Hands washed before donning gloves and after removing gloves. c. Gloves changed any time hand washing would be required. This includes other non-food contact surface, such as door handles and equipment. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Staff should be reminded that gloves become contaminated just as hands do, and should be changed often. When in doubt, remove gloves and wash hands again. The Facility Monitoring Food Temperature For Meal Service Guideline and Procedure Manual dated 2020 revealed the following: a. Prior to serving a meal, food temperatures taken and documented for all hot and cold foods to ensure proper serving temperatures. Any food item not found at the correct holding/serving temperature will not be served but will undergo the appropriate corrective action listed below. b. If the serving/holding temperature of a hot food item is not at 135 F or higher (check your state specific regulations: some states require 140 F minimum hot holding temperature) when checked prior to meal service, the item will be reheated to at least 165 F for a minimum of 15 seconds. The item may be reheated only once and must be discarded or consumed within two hours. Any reheated item that is left after meal service or held longer than two hours is discarded. c. If the serving/holding temperature of a cold food item or beverage is not at 41 F or below (for less than four hours in duration) when checked prior to meal service, the item will be chilled on ice or in the freezer until it reaches 41 F (or less) before service. d. Meals served on room trays may be periodically checked at the point of service for palatable food temperatures. Food temperatures of hot foods on room trays at the point of service are preferred to be at 120 F or greater to promote palatability for the resident.